

**The Leeds Teaching Hospitals NHS Trust
Strategic Direction
2009-2014**

**Version 3
25 June 2009**

1. EXECUTIVE SUMMARY

The Leeds Teaching Hospitals NHS Trust (the Trust) is considering an application for Foundation Trust (FT) status in October 2010. The application process is stringent and Monitor will expect and require a clear business strategy from any applicant organisation.

The purpose of this document is to draft an outline strategic direction for consideration by the Trust Board prior to the detailed work required for the Integrated Business Plan (IBP). It is grounded in the reality and evidence of the Trust's current position and the need for effective change management to address the clinically driven change agenda set out in the Darzi report. This will require workforce modernisation, efficiency gain, cost base reduction and the increasingly challenging and transparent clinical governance and quality agenda. Perhaps the greatest challenge is the need to improve efficiency and margin, and to drive up quality simultaneously. The Trust must recognise the current realities and aspire to a sustainable and successful future.

The Trust's current position is set out in the 2009/10 business plan which is based on the need to address patient safety, access, quality and productivity. This includes developing clear and credible plans to deliver financial balance, a financial baseline with the PCT, the fulfilment of health care associated infection targets and the achievement of access and quality targets. These are challenging issues which must be solved if the Trust is to move forward with a feasible strategic direction.

This document sets out the generality of the future environment and describes what requires further investigation to properly inform our IBP. It also acknowledges that there will be external changes that the Trust will be required to gauge and incorporate, for example:

- The economic downturn and an extremely challenging public sector financial environment with almost certainly no growth after 2011 and the prospect of financial cuts in real terms;
- National policy changes: with demand and quality targets linked to funding;
- Consumerism of the NHS: the political and economic direction of travel;
- Leeds PCT: host commissioner ambitions (programme budgeting, World Class Commissioning);
- Capacity: what will happen to demand after the 18 week backlog has been cleared, in what setting will Trust capacity be based;
- Changes to the clinical models of care required: both externally and internally;
- The impact of both NHS and private sector competition.

The challenge is daunting but the Trust should not lose sight of some of its tremendous attributes that can, and will, be developed in the medium term. In particular:

- A broad business portfolio that covers DGH, regional and national tertiary services;
- Opportunities in education, Research and Development, private work and a variety of other activity and income streams;

- A large estate with a mixture of buildings of various vintage and suitability that should offer interesting planning opportunities;
- A professional and expert multidisciplinary workforce with good levels of specialisation and sub specialisation that provide future opportunities to develop new services and export their expertise to other health care providers;
- Good working relationships and arrangements with Leeds University which again offers much potential for development in support of a joint future agenda;
- Finally there is the opportunity to develop a joint agenda with, and gain the support of, Leeds PCT who are very keen to work with the Trust during any agreed period of transition.

Picking up on the strengths and challenges stated above it is essential that other organisations have confidence in the Trust's ability to deliver its plans. The growth in Leeds residents being treated in neighbouring trusts is testament to the failure to achieve, by a large margin, the Trust's agreed activity levels which has adversely affected the Trust's reputation with its host PCT. The pace of change is accelerating and to ensure a successful and sustainable future, the Trust needs to accelerate its own pace of change. The IBP will therefore set out the Trust's medium term strategy based on the following principles:

- Seek to partner Leeds PCT in fulfilling their strategy and making the Trust the "Health Provider for Leeds";
- Consolidate share of secondary services, securing future referrals at source and repatriating work previously lost;
- Remodel tertiary services to fulfil Healthy Ambitions and achieve a return on our investment similar to other regional centres;
- Maximise innovation and teaching opportunities;
- Provide IT systems that will provide a competitive advantage in managing patient care in different settings and enhance quality and efficiency;
- Provide the support and infrastructure to maximise the time clinical staff have available for patient care;
- Improve the quality of the information which drives the funding of the organisation;
- Make the Trust estate fit for purpose and maximise its use;
- Develop a workforce strategy that keeps pace with the new models of care (including IT) and reflects the upper quartile benchmark against peers;
- Develop capacity, demand and competitor modelling capability to form intelligence networks in line with the Trust's change agenda and the "any willing provider" mindset;
- Build quality and consumerism into Trust investment decisions and review of performance;
- Involvement of staff throughout the organisation in the formulation and achievement of the Trust strategy;
- Develop a clear and credible plan to deliver and maintain financial surplus.

Overriding all of the above is the absolute priority of ensuring that the quality of services is improved, recognising that failure to do so will seriously, possibly terminally, affect the Trust's future. In doing this all staff must be engaged in ensuring that the Trust's services thrive in an environment where increasingly the business of health provision is seen as a commodity and measured against

consumer based indices. In large part this strategy is recognising and reacting to the steady influence of these values shaping how healthcare is provided.

2. LINK TO STRATEGIC GOALS

The Board laid down the mission of the Trust as: “to ensure that the Leeds Teaching Hospitals NHS Trust is a locally, nationally and internationally renowned centre of excellence for patient care, education and research. We will deliver this by ensuring we employ the best possible staff and invest in their development.” Since 2007, the mission has been supported by three strategic goals, these are:

- Achieving excellent clinical outcomes;
- Improving the way we manage our business;
- Becoming the hospital of choice.

The strategy embraces the ethos captured in the Trust mission and three strategic goals and it is focused upon their successful implementation.

3. CONTEXT

The strategy for hospital provision in Leeds was last set out in the 1997 Leeds Health Authority document “The Future of Health Services in Leeds”. This proposed the merger and reorganisation of a number of hospital services across the city. The Leeds Teaching Hospital Trust was formed in April 1998 and submitted a Strategic Outline Case in September of that year which built upon this model. This document proposed a new oncology facility at St James’s Hospital, a children’s hospital in the Clarendon Wing, the maintenance of two A+E departments, trauma services to be concentrated at Leeds General Infirmary (LGI), reconfiguration of Seacroft and Chapel Allerton and a new Wharfedale hospital.

The final piece of work in fulfilling this strategy has commenced and is currently in the last stages of business case approval. It proposes the centralising of inpatient children’s services at LGI and adult medical services at St James’s Hospital. On completion of this, all inpatient services, other than maternity, neonates and gastroenterology, will be provided on one site or another with the removal of duplication (see appendix 1). Although the benefits of the 1997 strategy can be debated with hindsight, the maintenance of parallel services across the city was not sustainable once the decision had been taken to merge the Leeds Trusts.

In 2005 the Government introduced Foundation Trust status, requiring “all NHS Trusts to be in a position to achieve foundation status” (271433/A A Short guide to NHS Foundation Trusts 2005). Since 2005, most large hospitals in Yorkshire (62%) have successfully achieved Foundation Trust (FT) status and have built financial surpluses during a time when the national economy and the local health economy were buoyant. In general FTs appear to be working well, achieving both their quality and financial targets and developing their regime freedoms.

Despite its progress in reconfiguring services, the Trust has not applied to become a Foundation Trust. Discussions have taken place with the Strategic Health Authority (SHA) with an application date of October 2010.

4. IDENTIFICATION OF STRATEGIC CHALLENGE

The majority of hospitals in England now have Foundation Trust status and most have been successful in achieving a financial surplus and an enhanced ability to invest in their services. Although the Trust has come relatively late to this process and is likely to be making an application in a time of economic uncertainty, it would seem sensible to continue the working assumption that the FT process will be maintained, as FTs could well be portrayed as having the skills energy, innovation and resilience to better weather the challenges ahead.

The strategic challenge for the Trust will be to learn from, catch up, and where possible “leapfrog”, other organisations to meet national quality targets and achieve an FT level of return. To achieve this confidence will have to be engendered in our regulators, commissioners, referrers and patients. The Trust’s plans, actions and performance must demonstrate that the organisation is capable of delivering sustainable high quality care and financial stability.

Improving the way we manage the business will focus upon costs, efficiency and productivity compared to other similar trusts. The scale of the financial challenge this represents has been previously discussed at the Board and is set out in section 6.

5. Commissioners and Markets

Selected below are the more important policy drivers from commissioners and the likely key competitors that will affect the Trust’s future over the next five years.

5.1. Leeds PCT

Leeds PCT Strategy 2008-2011 outlines the PCT’s vision and its six priorities for investment (Saving lives and reducing health inequalities; improving health wellbeing and healthcare; responding to changing population needs; sustaining performance against core access and safety standards; shaping the provider landscape and becoming World Class Commissioners). Their strategy seeks to reduce hospital admissions, particularly for patients with long term conditions who would be managed closer to their homes in line with the Healthy Ambitions guidance.

As part of their strategy the PCT are implementing a market management arrangement to introduce competition in their choice of health providers for certain conditions. This involves new models of care based in the community which will include some services currently provided by the Trust. An example would be diabetes management. The PCT has already invested significantly in the LIFT building programme thus “pump priming” the market and introducing the “any willing provider” arrangements to encourage new entrants to the market.

The Leeds PCT, and the wider commissioner community, also aspire to move to an arms length basis of commissioning cancer services with the Trust in the lifetime of this strategy such that they would no longer assist in the payment for Bexley Wing. This has significant financial implications.

The above represents an ambitious plan which needs both substantial investment on behalf of the PCT and, if successful, could change the profile and quantum of activity the Trust will serve. In recognition of this agenda the two bodies have agreed that a major piece of work is required by June to ensure that both organisations are meeting their statutory, service and public obligations.

5.2. SHA Healthy Ambitions

Healthy Ambitions (2008) sets out the Yorkshire and Humber response to the NHS's Next Stage Review, led by Lord Darzi. It aims to shape the NHS over the next decade, addressing the best practice in care from birth to end of life. Enacting this guidance will require new patient pathways, for a variety of conditions, some long term, some acute such as patients suffering a stroke. Hospital care will therefore change quite significantly with some more specialised services concentrated in tertiary centres and available over 24 hours, other work being moved to the community. As patients pathways become more sophisticated, this will require better IT communications as more complex clinical information is exchanged across agency.

5.3. Clinical Networks

Clinical Networks involve a variety of health staff and organisations from primary, secondary and regional health care ensuring that relatively rare conditions are dealt with by experienced and competent teams of staff. In Yorkshire these include cancer, cardiac services, critical care and neonatology. Not all services commissioned regionally by the Specialist Commissioning Groups have Clinical Networks but the formalisation of their competency is likely to become more widely endorsed. The networks will be driven by Healthy Ambitions and the clinical change agenda and different models of where and how this kind of care is delivered will emerge.

5.4. Surrounding FTs

LTHT is surrounded by four FTs. All of the FTs have endorsed and adopted the core principles that underpin that regime which include acting independently in a way that is outwith historical SHA/PCT boundaries and local catchment areas, this with a view to maximising their activity, income and bottom line.

This includes a very active local provider which has been exploiting the Trust's vulnerability in access to secondary care. This initially affected the east of Leeds for orthopaedic services, a service they plan to expand by 5% year on year. We understand that they are also looking to secure referrals for maternity and gynaecology and grow these businesses reference orthopaedics above.

Their business plan is "to deliver hospital services to a wider population". Their contract with Leeds PCT was £11m in 2007/8, in 2009/10 it will grow to a value of approximately £20m. They have been successful in achieving a wider catchment population in recent years and they continue to be a threat to the Trust's secondary services and, potentially, as a player in Leeds PCT market management plans.

Another local FT is progressing their plans for urology and upper GI cancer services as agreed with the clinical network. In services that are not covered by clinical networks,

they have appointed an additional orthopaedic surgeon and will develop this speciality including paediatric orthopaedics. Their intention is also to develop other regional speciality services such as obesity surgery, paediatric ICU and PET CT. Their development of tertiary services should be closely monitored and the Trust will need to develop a more reliable market share intelligence system to ensure that this takes place effectively.

Yet another FT will commence a substantial new building programme this year and improve the quality of their accommodation and through this hope to attract additional clinical activity. Their contract for Leeds residents has increased by £6m over the last two years to approximately £22m. Their current activity profile shows half of their ten thousand Leeds cases to be acute admissions and three quarters of the electives to be day cases. Orthopaedics, ENT and ophthalmology are significant elective specialties.

The fourth FT has been successful in generating substantial operating surpluses which they have used to reinvest in services e.g. capital and revenue in ICU, cardiac services, haematology/BMT, genito-urinary and dental services. Historically their impact has not been significant on LTHT activity but they are only a relatively short distance down to the south of us and offer a good range of high quality DGH and tertiary services.

5.5. Practice Based Commissioners

Practice Based Commissioners (PBCs) operate throughout the Leeds area.

To date the PBCs have been interested in arranging outreach services and some will wish to be involved in the Leeds PCT market management initiative for services in the community. Specialities in these categories include dermatology, maternity, diabetes, neurology, COPD (respiratory), falls and dementia. There are private firms such as Assura who offer joint ventures with GPs to provide buildings and IT facilities

5.6. Leeds PCT Provider Arm

The Leeds PCT provider arm has a turnover of £90 million, employing nursing and clinical staff in the community. Leeds are one of seven local community providers who have expressed interest in becoming a Community Foundation Trust (CFT), the others being Barnsley, Doncaster, East Yorkshire, North Yorkshire, Sheffield and Wakefield. Their desire to be a CFT and the Trust's desire to become the Health provider for Leeds might form the basis of a discussion with the PCT.

6. EXTERNAL ENVIRONMENT

6.1. National Economic Outlook

Treasury Forecasts

The national economic outlook is particularly unpredictable as this document is drafted. Below is the current average of independent forecasts for gross domestic product, inflation and unemployment for the next five years.

Description	2009	2010	2011	2012	2013
		%	%	%	%
GDP growth (%)	-3.9	0.2	1.9	2.4	2.6
Inflation rate (CPI %)	1.6	1.5	1.5	1.8	2.0
Inflation rate (RPI %)	-1.3	1.7	2.3	2.9	2.5
Unemployment claimants (mn)	1.74	2.27	2.23	2.09	1.91

HM Treasury: Forecasts for the UK Economy, Comparison of independent forecasts May 2009

Public spending as a whole is unlikely to increase in real terms over the next five years. Financing the cost of increasing unemployment will reduce the proportion of resources available to other spending departments, requiring real reductions in these areas.

The Private Finance Initiative unitary payment indexation is linked to the retail price index (RPI) and not the consumer price index (CPI). The RPI includes housing costs and council tax, and is calculated in a different way, so it tends to be higher than the CPI. Annual funding uplifts are historically linked to CPI. The volatility of current predictions is further illustrated by a table published by Monitor:

SUPPLY SIDE	Bank of England - Q2 2009 prediction (May 2008 model)	
Instability in the financial markets severely affecting business investment decision both directly and through the supply of bank lending. The financial sector is a key driver for UK economic growth and is likely to experience negative growth in the near term.	GDP 1.5%	CPI 2.1%
DEMAND SIDE	Bank of England - Q2 2009 prediction (Feb 2009 Model)	
Evidence now of falling house prices, with a risk of further falls generating negative equity problems for many borrowers - reduces consumers access to secured credit, Consumer confidence has fallen sharply in recent months.	GDP -4.39%	CPI 1.6%

Wage aspiration

Wage aspirations are traditionally linked to the inflation rate which current predictions show to be volatile over the next five years. The next national three year wage agreement is due to start in April 2011 which is forecast to be a time of rising inflation. The February Treasury forecast may also not have taken account of the recent decision to increase the money supply (quantitative easing) which some commentators believe could further increase inflation during 2010/11. It is possible that although there might be significant structural unemployment, there could also be relatively high inflation which

could make negotiations around the 2011 wage round unstable with a pay settlement in excess of funded expectations.

Any pay negotiation needs to be seen in the context of the overall growth in public sector spend as a percentage of total GDP. It is likely that post the immediate financial crisis, there will be a drive to reduce this percentage and consequently a strong government resistance to above inflation pay awards going forward.

General Election

There will be a general election by 2010. In the event of a Conservative government, their document Renewal - Plan for a Better NHS, sets out a change of emphasis from central targets to a range of information published to enhance patient choice, with a specific mention of health outcomes. The document promises more autonomy for health professionals, an increased role for GP budgets, plurality of health providers and an independent board to run the service. There is also an emphasis on eradicating HCAI and a consumerism theme with the creation of 45,000 more single bedded rooms. In terms of overall spending, the pledge is for a real increase. There is no suggestion that tariffs will be significantly altered and an enhanced role for Monitor would suggest refinements on the current financial system rather than a wholesale change.

Labour's policy develops existing themes particularly extended opening hours for GP practices, healthcare acquired infections, screening and mental health. There is no specific spending commitment and there is no suggestion that funding mechanisms will be significantly altered. Specifically mentioned in the policy section of the Labour party's website is the assertion that "since April 2008 all patients have been able to choose from any hospital provider in England that meets NHS standards and costs, giving patients more control and helping to drive up standards."

Obviously both the major parties have yet to publish detailed manifesto proposals and current policy statements may not have been updated in the light of the recent public sector borrowing figures. It would seem however, that patient choice and consumerism will continue to be a major tenet of government policy regardless of which party is in power after 2010.

Suppliers

The national economic outlook will also affect the Trust's suppliers. The Trust will continue to seek to utilise its purchasing policies to reduce costs by procurement leverage, automated stock control systems and e-enablement technologies. The general economic downturn should strengthen the Trust's position in achieving savings from suppliers.

The Trust is committed to treating its suppliers fairly and will seek to adhere to the Public Sector Payment Performance regulations ensuring that 95% of suppliers are paid within 30 days. There is a risk however that some important suppliers may experience difficulty in remaining solvent. Currently contingency plans are being drawn up in the event that B Braun (sterilised instruments) and Patientline (bedside TVs) might cease trading.

Private Patients

The Trust's private patient income is relatively small (£2.5m). Given the changing nature and culture of the NHS however this document will act as a mandate to revisit the Trust approach to private patient income.

As part of the FT application the Trust will develop an IBP as part of the Monitor process and further refine all assumptions, recognising that they will be expertly challenged by Monitor.

6.2. Local Health Outlook

Leeds PCT strategy predicts a rise of 25% of people aged 65 and over by 2030, with an increase of 35% of those aged 85 and over. Birth rates in Leeds will continue to rise above the national average with a 30% growth in the population predicted by 2030. The city is growing at almost 1.5% per year (see appendix 2). Leeds also experiences health inequalities by area with a 9 year difference in life expectancy. Alcohol related illness is double the national average in some council wards. Cancer outcomes are worse than the national average, some areas have relatively high infant mortality and there has been a rise in obesity across the population over recent years. One of the key pieces of work the trust is required to undertake in the short term is to test the underlying assumptions behind these figures and model the implications to the Trust in its aspiration as the health provider for Leeds.

The likely effects of deteriorating economic conditions on the Leeds population are not clear. The SHA have joined the government sponsored Economic Delivery Group, chaired by Rosie Winterton, Regional Minister. Their current research suggests that in areas of high and prolonged unemployment in the 1980s there was an increase in GP consultation rates of 20-80%, and an increase in hospital admissions of 33% by those who had become unemployed. Areas of concern were alcohol, tobacco, mental health and obesity. The net effect on the Trust will depend on a number of factors and is one of the issues that the Trust will consider in developing its five year activity forecast and capacity plan. For example, such patients often have co morbidities and can be heavy users of facilities such as critical care beds. They are also likely to be admitted acutely which will affect the Trust's ability to plan the elective caseload and achieve its access targets.

6.3. NHS Local Financial Outlook

The 2007 Comprehensive Spending Review (CSR) was announced in October 2007 and sets out the NHS resource envelope for the next 3 years (2008/09 to 2010/11). The SHA has provided a set of local planning assumptions, outlined in the following table:

Description	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Allocation Uplift - to PCTs	5.5 - 6.3	5.5 - 6.3	4 +/- 0.5	4 +/- 0.5
Tariff uplift (gross)	5.8	5.8	4	4
National Efficiency Target	-3.0	-3.5	-3.5	-3.5
Tariff uplift (net)	2.8	2.3	0.5	0.5

In terms of commissioners' ability to pay for growth in services in acute and primary care, this will become increasingly difficult after 2011.

7. STRATEGIC DIRECTION

Picking up on the strengths and challenges stated above it is essential that the Trust recognises that the pace of change is accelerating. To ensure a successful and sustainable future, the Trust needs to accelerate its own pace of change. The IBP will therefore set out the Trust's medium term strategy based on the following principles:

7.1. Achieving Financial Surplus

The financial challenge over the next five years is a significant one. Under the current Trust status the magnitude of savings is set out below:

Description	2009/10 % FIT	2010/11 % FIT	2011/12 % FIT	2012/13 % FIT	2013/14 % FIT
National efficiency target	3.0	3.5	3.5	3.5	3.5
Loss of Patient Care Income	1.0	1.0	1.0	1.0	1.0
Loss of research Income	0.5	-	-	-	-
Loss of education Funding	0.5	0.5	0.5	0.5	0.5
Loss of transitional financial support for Bexley wing	-	0.5	0.5	0.5	0.5
Unfunded cost pressures	-	-	-	-	-
Financial Improvement target %	5.0	5.5	5.5	5.5	5.5
Financial improvement result - £M	37.0	40.0	40.0	40.0	40.0

The national efficiency target is rising and there are a number of important local issues that require resolution (this includes the funding for Bexley Wing which will be dealt with by a separate paper). To become an FT it would be necessary to generate a further £10m per annum surplus (an extra 1.5% per annum), retain surplus to improve liquidity, improve the return on assets, generate additional cash and raise EBITDA from 5.5% to 8%.

There is evidence that the cost base of the Trust overall is too high. A process is necessary to quantify the efficiency gain that the Trust can reasonably be expected to deliver. The most readily available source is the use of reference costs to show the quantum of savings that can be achieved (recognising that the methodology includes infrastructure). This work will also be complemented by traditional methods such as CHKS.

Reduction in overheads is a key part of improving the Trust's cost base as illustrated by other hospitals' strategies (Bradford and Sheffield). This has increased importance in a health market where growth funding is declining. PLICS will be a vital tool in identifying what costs have a direct bearing on productivity and what costs are employed to support traditional teaching hospital roles, industry good practice or local desirable goals. This

process should then highlight a number of decisions affecting activities that might be significantly reduced or the Trust may no longer wish to support.

High level comparisons made with other Trusts, such as Newcastle and Manchester, suggest that they receive a proportionately higher level of income than this Trust enjoys per head of population with a proportionately smaller estate and fewer staff. Further work will take place to understand where the differences exist and which areas to concentrate upon for the highest return.

7.2. The Health Provider for Leeds

Leeds PCT will develop their model of market management as part of their pursuit of World Class Commissioning. This will involve testing the market based on new patient pathways, particularly the management of long term conditions giving the Trust and other organisations the opportunity to vertically integrate or offer existing care in different settings etc.

Vertical integration should offer the opportunity for health care to be joined up across existing organisational divides, such that patient experience and outcomes are enhanced. As it applies to this strategy, certain specific areas should be considered principally: where the Trust provides care closer to home with appropriate assessment, diagnostic and interventions in locality settings; working more closely with the PCT provider arm where the Trust can deliver services more cost effectively; by the Trust managing its demand through the provision of its own minor injuries and assessment centres; by better integrating clinical information flows and support services with the GP community including the provision of GPSI services which currently represent an opportunity to both the Trust and to alternative providers.

If this were achieved over a number of specialties, the Trust would start to shape it itself as the Health Provider for Leeds for locality and hospital care. This would prevent third parties from cherry picking the more profitable services, give some insulation from variations in any one specialty's demand, and preserve, at source, a critical mass of local demand once the "peak" of 18 week referrals is over. The various LIFT buildings would, in effect, be Trust outpatients.

Adopting this strategy would not mean that all locality proposals from Leeds PCT would necessarily be accepted. The pathways have not yet been agreed and some aspects of the service may be more suited to primary care. Similarly the costs of the relatively new LIFT buildings would, in the medium term, be in addition to existing Trust outpatient buildings.

This change in how services are provided across the city will require new and improved managerial links with the PCT and the PBCs in line with the ethos of the Health Provider for Leeds role and Darzi.

7.3. Secondary services - Choice

Inroads have been made into what has traditionally been the Trust's market for secondary services, particularly for Leeds residents in the north and east of the city. The value of the activity commissioned outwith LTHT has now more than doubled to an excess of £50m over the last few years. On the completion of the Trust's capacity plans,

it will be clear whether the Trust has the capability to win back this work by offering better quality and equivalent waiting times. The Trust will also look to PLICS financial analysis and enhanced market modelling to inform its response.

The Trust must develop a better method of tracking referrals across the city and the region, and plan to defend its secondary care markets actively. Regular dialogue should also take place with GP's and local patient groups, particularly in areas where other providers are doing the same. If patients and GPs are being encouraged to make choices, the Trust must listen to their views and act upon them. It is no longer possible to assume that the secondary care market in Leeds is a captive one for the Trust.

7.4. Tertiary services - Market expansion/penetration/retraction

The Trust has generally worked within clinical networks to develop service profiles and the Specialty Commissioning Group. A remodelling of many tertiary services will be necessary under the Healthy Ambitions guidance.

The Trust has been less proactive in taking the initiative in progressing tertiary services outside the clinical networks, a role that is currently of interest to other local FTs. Work will take place to assess how much income other Trust's are earning from this work to test whether the Trust is properly using the expertise and infrastructure it has in place. One organisation for scrutiny is Newcastle FT who have a city population of 260k and an income of £641m (2007/8), the Trust's comparable figure is a population of 715k and an income of £793m. Both Trusts had a similar share of income from PCTs and education etc. Increasing the productivity of tertiary services will better cover existing overheads and dissipate increases in Trust income over a larger number of commissioners.

There might be some "specialist" services which are unlikely ever to be adequately recognised by the tariff mechanism. Careful PLICS analysis would be required to calculate contribution and the potential for tariff change. Given the Choice guidance, a threshold, or Leeds only service, will not be possible and such services should be either discontinued or funded in a protocol agreed with commissioners.

7.5. Innovation and Teaching opportunities

There may be some areas where relatively few competitors have the required infrastructure to adopt new technologies. The Trust may therefore have a comparative advantage to be an early adopter of some services and achieve ground breaking clinical care and an income premium. Areas under current consideration are Proton therapy, Gamma knife and PET-CT.

The Trust will continue to pursue revenue generation in research and development,

intellectual property, teaching and education and business development. In particular it will look to build on the success in 2008/9 in winning a number of important competitive research bids and put emphasis on how these will translate into the early adoption of evolving cutting edge practice.

Detailed work on costing and charges will take place in these areas including their contribution to the Trust's core business of health provision. Exploiting the knowledge base of the Trust and actively pursuing a number of revenue generation opportunities from different agencies can collectively contribute to the organisation's productivity.

7.6. Information Technology

The Trust spends around 1.9% of its revenue on IT and information. IT capital investment is usually around £2m per annum, though it can be significantly higher and in 2007/8 was £9.95m as PACS was implemented.

The Trust strategy for Information and IT is to deliver high quality and secure systems that help improve the quality of patient care, satisfaction of patient experience, efficiency of the business and the reduction of costs. Clinical ownership will be at the heart of new modern IT systems.

IT investment plans should be set in the context of the increased development of the electronic patient record with fully delivered wireless technology enabling the access of patient information at the bedside. Within 5 years there will be a move away from paper records towards the widespread adoption of Picture Archive Systems (PACS). Prescribing, requests and results, note taking and clinical correspondence will also be moving to an electronic basis within this timeframe. The national vision of shared records will ensure that care provided at the Trust as part of a larger clinical pathway will be supported in different care settings and organisations by summary patient records. Better IT communications will be needed as more complex clinical information is exchanged across primary, secondary and community care. Systems will be supported by the next generation of data warehousing enabling the reporting of performance, audit and research information. Significant work will take place to drive improvements in data quality and the accuracy of patient data and information.

The NHS Informatics Review (2008) identified functionality that would make new systems acceptable to clinicians as an interim step to full electronic patient records. These five key elements (the Clinical '5') for secondary care are: integrated PAS (Patient Administration System); electronic requests and results; letters with coding (discharge summaries, clinic, A&E letters); scheduling (for beds, tests, theatres); electronic prescribing. The Trust will also require modern infrastructure to enable the fast secure delivery of this agenda.

These priorities will help shape the Trust's IT investment plans over the next few years. The Trust's immediate priorities include:

- PAS development including real-time data capture, bed management
- Clinical systems to support patient management and clinical audit

- Requests & Results system (including tests ordered in primary care)
- Maternity system & other clinical systems
- Electronic Discharge Advice Notes to GPs - including 'TTO' medication
- Regional Renal clinical system
- Dental clinical records system (National funding)
- Digital dictation / efficiency savings
- Investment to upgrade IT service support / new data centre
- Investment in technical infrastructure including WiFi (wireless networking)

The NPfIT (National Programme for IT) aims to deliver the next-generation of IT systems. These new systems would be provided by CSC (our local service provider), based around a fully-integrated 'Lorenzo' solution being developed by iSoft. However, following delays, Lorenzo Release 1 is only at the 'early adopter' stage. The Trust is committed to implementing Lorenzo provided that it is proven in a large-scale complex hospital setting.

The Trust will invest in the best modern IT systems and infrastructure either tactically, using NHS-approved framework contracts, or through Lorenzo as these next-generation systems are proven. The development of Health Information Technologies and Electronic Patient Records with high quality clinical decision support systems has the ability to transform practice, patient safety and improve patient care and experience. The key objective will be to allow clinicians to devote more time to hands on patient care and activity.

Accessing patient information at any Trust location, at the bedside and remotely from the Trust without the wait for casenotes or paper can deliver major benefits in outcomes and reduce inefficiencies. The availability of timely medical data with the introduction of integrated systems has many benefits including systematic and evidence based care and improved research capabilities. The development of patient systems will be teamed with continued advances in technology which have already delivered the ability to track medical devices, patients; telemedicine will allow remote consultations and the monitoring of patients conditions within their own homes by use of a range of internet connected body computing technologies will become a reality.

The Trust must position itself to take advantage of new technologies and they will be a key driver in the Trusts move towards a continuous improvement culture. The early areas for achievement will be the introduction of order communications, the introduction of the core infrastructure to support wireless technology and working with suppliers to test systems and their integration potential.

7.7. Estate

The estate has a land area in excess of 64 hectares (158 acres) and buildings with an internal floor area in excess of 500,000m² (5 million ft²). The running costs for the estate are around £80m per annum (capital charges, rates, maintenance, energy, PFI Unitary Payment). 59% of the Estate is classed as Category B or above for Functional Suitability. From the current reported physical condition and statutory compliance facets of the estate, the investment requirement to move to a satisfactory position (including backlog) over the next 4 years is in the region of £143 million in works cost, equivalent to a gross cost (including enabling, VAT and fees) of £214 million.

Work will take place to analyse patient and non patient areas, utilisation by site, key buildings, Division, function, and type of space including vacant areas. The use of space by third parties will also be a feature. A series of KPIs will be developed to enable comparisons between Divisions on estate performance and this will be benchmarked with other Trusts. This will be used to promote discussion on how to improve areas of poor performance including the repatriation of poorly used space.

The Estate Strategy will provide Development Control Plans for each hospital site based on the planning assumptions included in the recent paper to the Trust Board. This will form the basis of investment guidance over the short to medium term. This will be key in aligning the estate with the Capital Programme.

The Estate Review will undertake a strategic option appraisal to inform the shape of the estate over the longer term. This will produce an Investment Plan setting out the improvement of retained estate to meet the core business needs, and the disinvestment in those part of the estate that are not essential to the core business. This will then be merged into the Integrated Business Plan needed for FT submission.

Capital is no longer a free good and the Trust must have a long term plan for how it delivers care to its patients. This will include how it can best organise its own sites and how it can contribute to Healthy Ambitions and Leeds PCT World Class Commissioning in delivering services elsewhere. Given the forthcoming election, there will be enhanced sensitivity, on the reduction in hospital accommodation, particularly those which provide good quality employment in an isolated area such as Otley. The Estates Review should demonstrate which buildings and sites contribute to productivity. The Trust may wish to discuss with the PCT whether unproductive sites that provide a social benefit to the local population should be financed to reflect that role.

It is recognised that clinical practice will not remain static, service provision will no longer be dominated by building stock and there are an increasing array of new channels of service provision. The influence of Choice and consumerism will also increase and the long term financial challenge affecting the whole public sector will continue to drive a strong focus on developing and implementing different clinical models. The Trust Board has approved the Clinical Service Reconfiguration programme delivering major changes to where paediatric and medical services are provided. The challenge is to build on these important initiatives and to further facilitate effective care being delivered from the most appropriate facilities. The estate strategy will be strongly influenced by these clinical considerations and the key driver will be supporting the ethos and ambition of clinical services, allowing clinicians to spend more time caring for patients thus enhancing the quality and cost effectiveness of the Trust's services.

7.8. Patient Experience

There is an increasing focus on patients as consumers which is driven by national policy and legislation as well as by patients, carers and members of the public themselves. Alongside this is a focus on quality and the two are linked in the Darzi report where it is stated that "Quality of care includes quality of *caring*" including the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction through their own experiences

Emphasis should therefore be given to the Trust's Patient Carer and Public Involvement Strategy. This uses a range of methods to assess patient experience and to make improvements, including information from complaints/PALS. It is essential that these are further developed and used to shape and improve services, as well as being clearly evidenced because the Trust's external regulators, internal and external auditors, the PCT (and other commissioners), the overview and scrutiny committee, patient groups and the Local Involvement Network (LINK) will want to see it and use it. This agenda will be further enhanced and driven through the medium of Governors which the Trust will have in place when it achieves FT status.

Patient reported Outcome Measures (PROMS) (heralded by Darzi) are being rolled out nationally and it is intended that many procedures will be covered by these in the future. Currently there are four. The Trust is expected to participate and performance will be monitored nationally and by the PCT. Ultimately performance in these areas could influence Trust income and patient choice.

There can be little doubt that the government will use its patients' choice agenda to drive improvements in the patient experience including a full spectrum of quality measures such as building infrastructure, dignity and respect, HCAI and clinical outcomes.

7.9. Workforce Modernisation

It is the Workforce that delivers 100% of the services the Trust provides, and accounts for 64% of spend. If the Trust is to thrive in the future, it is vital that it plans for and achieves a workforce with the right competencies to deliver the services commissioned by PCTs and others. This in turn requires a workforce that is aligned with service and process redesign, is flexible, is responsive to change, and is affordable. Across the Trust the overall cost of labour will be the key variable in achieving a financial surplus and levels of efficiency in line with the top quartile of peers will be the target.

Workforce modernization therefore needs to be at the heart of the Trust agenda going forward. Delivering the change set out in the clinical service delivery model will depend crucially on having the right workforce in terms of capacity and capability at the same time significant and emerging nationally led changes including advances in knowledge and technology are impacting the shape of the NHS workforce and will need to be taken into account as we develop a strategic workforce model as a basis for future planning.

7.10. Capacity Planning

It is essential that the Trust has a robust capacity plan. This must demonstrate that each specialty can deliver the volumes in its business plan without breaching its access targets or increasing its average costs. This might require more in-house capacity to be created or through other arrangements agreed with commissioners. The Trust wishes to work closely with PCT colleagues on a medium term model to agree explicitly what contribution the Trust's capacity can make to demand within the health economy. To contribute to this process, it will be necessary to maximise all appropriate bed areas and bring back into clinical use areas on wards that have been converted for other purposes. This will be achieved without adding to average costs or contravening safety or mixed sex guidance.

The long term financial plan (January 2008) set out a number of assumptions around length of stay, new and follow up outpatient rates and other indicators. This analysis predicted the freeing up of 181 beds between 2009 and 2013. This work will also be updated critically reviewed as part of our benchmarks in the run up to a potential FT application.

7.11. Quality and consumerism

The Trust recognises the direction of travel of Government policy, and that of the Opposition. The Department of Health and politicians are systemising both quality of care and the patients' experience. It seems inevitable that this consumerism agenda will continue and become increasingly sophisticated. Information that is designed to shape patients' choice will be provided and appropriately packaged. The Trust needs to be increasingly vigilant regarding the standards it works to and the evidence it will present to underscore the quality of its various services. It is likely that the Trust will have to invest both directly and indirectly in systems and delivery while preserving its financial objectives.

An initial set of quality indicators was agreed by PCT Chief Executives and the SHA Chief Executive and will be included in all PCT contracts from 1 April 2009. The Next Stage Review included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. It is the intention that year one of the scheme will focus on setting the baseline data and embedding the scheme within business processes. In 2009/10 Trusts will earn the CQUINs payments (0.5% of contract value)

The scheme in 2009/10 is therefore the first year of what will become a complex consumerism agenda, rewarding quality as well as volumes as indicated in the NHS Next Stage Review. To make the scale of changes necessary, there is a requirement to change systems but also to engender an ethos of organisational ownership, engaging all staff groups in contributing to the success of this agenda in their wards and departments.

7.12. Staff Involvement

The Trust recognises that as the pace of change increases there will be a multitude of different choices to be made. It is essential that the consultant staff and the wider clinical community are involved with this process. The Trust has had good relationships with its staff groups and this has provided a base on which to build further. A cross section of staff will be involved in the forthcoming quality/finance/efficiency workshops and this type of event will be continued over the coming months. A regular communication cascade has also been instigated within the directorates to ensure that all clinical staff are up to date with Trust issues.

If the Trust is to be successful in making the magnitude of changes necessary over the next few years, strong leadership and involvement will be required across all its staff groups. Consultant staff will be key players in the management of change and the Trust will endeavour to capitalise upon their drive, energy and enthusiasm to improve quality outcomes, reduce waste in the system if suitably supported, keep the Trust clinical strategy and practice to the fore, and engender seamless transition of information and ideas between clinicians and managers.

7.13. Managing our Business

This strategic direction provides some key drivers that will shape how the Trust will improve the management of healthcare provision in Leeds. The FT application process will encourage the Trust to further develop a devolved approach to managing at specialty, directorate and divisional level, supported by enhanced autonomy and responsibility. The current model will need to consider, and potentially embrace, service line management (SLM) which, at its core, proposes devolved I+E responsibility linked to investment and spend flexibility and will act as a major catalyst for medical engagement and enhanced service delivery. SLM addresses the often cited criticism that the existing structure does not either incentivise good performance or address poor performance.

The earlier section on IMT paints a picture of the future and there is no doubt that future information systems will need to integrate and support the chosen management model, incorporating activity, financials and quality outcomes. Shortfalls in this area will severely compromise the Trust's ability to deliver effective management.

Sitting perhaps at odds with the concept of SLM is the need to give more consideration to how corporate services are delivered, particularly for services where an LTHT uniform approach is required. It is essential to formulate a common approach to a range of issues including how patients are put on waiting lists, how they are booked into theatre or how their outpatient clinics are organised. Identifying and implementing best practice will be a critical factor in improving the services of the Trust.

If the above describes the process of managing our business, considerable attention should also be paid to the support, training and education required for the clinical and non clinical managers who will be charged with delivering this strategy.

This document has not majored on the quality, activity and productivity agenda which will be brought together in the Long Term Financial Model and the Integrated Business Plan. If the Board endorses this strategy, the challenge for the Board and the wider Trust will be to develop the organisation and turn the aspirations of this document a reality.

8. ACTIONS

The Board is asked to approve the Trust Strategic Direction.

Brian Steven
19.6.09

Appendix 1

INPATIENT SERVICES CENTRALISED FROM FORMER SJUH AND ULTH TRUST HOSPITALS SINCE SINGLE TRUST FORMED APRIL 1998

Position Prior To Single Trust:

- 1998** All adult inpatient services duplicated apart from urology, ENT/oral max fax, BMT, cystic fibrosis, infectious diseases, neurosurgery, cardiac surgery and hepatology. All childrens services duplicated apart from oncology/haematology, hepatology, cystic fibrosis, cardiac surgery and neurosurgery.

Centralisations Between 2004 - 2008

- 2004** Centralisation of elective orthopaedics at CAH
- 2005** Centralisation of rheumatology at CAH
Centralisation of neurology at LGI
- 2006** Centralisation of thoracic surgery at SJUH
Centralisation of orthopaedic trauma and orthopaedic spinal surgery at LGI
Centralisation of plastic surgery at LGI
Centralisation of hand surgery at LGI
Centralisation of renal medicine at SJUH
Centralisation of vascular surgery at LGI
Centralisation of gynaecology at SJUH
Centralisation of ophthalmology at SJUH
- 2007** Centralisation of breast surgery at LGI
Centralisation of respiratory medicine at SJUH
Centralisation of cardiology at LGI
- 2008** Centralisation of haematological malignancies at SJUH
Centralisation of non surgical oncology at SJUH
Centralisation of colorectal surgery at LGI
Centralisation of upper GI surgery at SJUH

Centralisations That Took Place Between 1998 - 2008

- All 6 elderly wards at CAH taken out of CAH and moved into LGI/primary care
All 8 elderly wards at Seacroft taken out of Seacroft and moved to SJUH/primary

care.

Centralisations Due To Complete 2009/10

2009 Centralisation of reproductive medicine at Seacroft

2010 Centralisation of adult acute medicine at SJUH

Centralisation of all childrens services at LGI

Centralisation of older people's medicine at SJUH

Only Inpatient Services Not Centralised By The End Of 2010

- Maternity
- Neonates
- Gastroenterology

Appendix 2

Population and Growth (Office for National Statistics: Local Authority population)

Area changes 2006-2007	Mid-2006 population	Live births	Deaths	Natural change	Net migration*	Total change	Mid-2007 population
Yorkshire and the Humber	5,142.4	63.4	50.4	13.0	21.8	34.8	5,177.2
East Riding of Yorkshire UA	330.9	3.1	3.4	-0.3	2.4	2.1	333.0
Kingston upon Hull, City of UA	256.2	3.5	2.5	0.9	-0.2	0.8	257.0
North East Lincolnshire UA	158.9	1.9	1.7	0.2	-0.7	-0.5	158.4
North Lincolnshire UA	159.0	1.8	1.6	0.2	0.2	0.4	159.4
York UA	191.8	2.0	1.7	0.3	1.2	1.5	193.3
North Yorkshire	591.6	5.8	6.1	-0.3	4.3	4.0	595.5
Craven	55.5	0.4	0.6	-0.2	0.6	0.5	56.0
Hambleton	86.3	0.8	0.8	0.0	0.6	0.6	86.9
Harrogate	157.8	1.6	1.6	0.0	1.0	1.0	158.8
Richmondshire	51.0	0.6	0.4	0.1	0.3	0.4	51.4
Ryedale	52.9	0.4	0.6	-0.1	0.5	0.4	53.3
Scarborough	108.3	1.1	1.4	-0.3	0.4	0.1	108.4
Selby	79.8	0.9	0.8	0.2	0.8	1.0	80.8
South Yorkshire (Met County)	1,292.9	15.9	13.2	2.7	3.9	6.6	1,299.4
Barnsley	223.5	2.7	2.5	0.2	0.9	1.1	224.6
Doncaster	290.3	3.7	3.1	0.6	0.2	0.8	291.1
Rotherham	253.3	3.0	2.5	0.5	-0.4	0.1	253.4
Sheffield	525.8	6.5	5.1	1.4	3.1	4.5	530.3
West Yorkshire (Met County)	2,161.2	29.4	20.1	9.3	10.7	20.0	2,181.2
Bradford	493.1	8.1	4.6	3.6	0.7	4.3	497.4
Calderdale	198.5	2.5	1.9	0.6	1.0	1.6	200.1
Kirklees	398.2	5.6	3.8	1.8	1.0	2.8	401.0
Leeds	750.2	9.3	6.5	2.7	8.1	10.9	761.1
Wakefield	321.2	3.8	3.2	0.6	-0.2	0.5	321.6

*plus other changes